Neoliberalism: what it is, how it affects health and what to do about it

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ABSTRACT

Since the 1970s, neoliberalism has been the dominant economic and political philosophy among global institutions and some Western governments. Its three main strategies are: privatisation and competitive markets; reduced public expenditure on social services and infrastructure; and deregulation to enhance economic activity and ensure freedom of 'choice'. Generally, these measures have negatively affected the health and wellbeing of communities. In New Zealand, privatisation and competition led to income inequality and an unequal distribution of the 'determinants of health', a burden borne disproportionately by children, the poor, and by Māori and Pacific people. Limiting health expenditure led to inequalities in access to services with restructuring in the 1990s, subverting the service culture of the health system. Failure to regulate for the protection of citizens has undermined health and safety systems, the security of work and collective approaches to health improvement. There has been some retreat from neoliberalism in New Zealand, but we can do more to focus on 'upstream' health initiatives, to recognise that social investment, including adequate funding of services, returns benefits far in excess of any costs, and to make sure that social and cultural equity goals are achieved.

This paper sets out the consequences of neoliberalism for health. Among health workers, including doctors, nurses and managers, there are some with a poor understanding of neoliberalism or who assume that this is the only way to organise our economies and institutions. Neoliberalism has been described as the 'idea that swallowed the world'.[1] We argue that the world also 'swallowed' (uncritically accepted) neoliberalism, and that this should be challenged. We trace the rise of neoliberalism, including its emergence in New Zealand and its implications for health. Finally, we suggest some changes that could mitigate the worst consequences of neoliberalism for health and ensure responsiveness to growing and unmet need.

The rise of neoliberalism

Classical liberalism is an ideology and policy model that emphasises personal and economic freedom and a small role for the state, allowing individuals to pursue their own interests.[2] Originating among eighteenth century philosophers, through the nineteenth century, liberalism was reflected in laissez-faire economic policies that encouraged industrialisation and new models of labour and capital, in short, the modern economy. Classical liberalism relied on the market with minimum interference from the state, either by regulation or taxation. Government's role was to keep order, protect property and create a secure environment for the pursuit of commerce.[2]

The liberal model fell into disfavour in the mid-twentieth century when the upheaval of the Great Depression suggested a greater role for governments in managing economies. Drawing on the economic theories of JM Keynes, Western governments accepted the idea of intervention in economic management and promoting prosperity through welfare states.[3] Early international examples included New Deal policies in the US in the 1930s to address impacts of the Great Depression and comprehensive welfare state legislation in New Zealand in 1938. Over subsequent decades alternative versions of welfare states emerged in Western countries. The three main types are set out in Table 1 (adapted from Schrecker and Bambra,[4] with permission).

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Table 1: Main types of welfare states.

Social democratic (the 'Nordic' Model)
This includes countries such as Norway, Finland, Sweden, Denmark and Iceland. Income support and social services, including health, are funded predominantly from taxation.
Bismarckian (Social Insurance Model)
This model is typical of continental European countries such as France, Germany, Italy, Netherlands. Income support, social and health services are largely funded through employer and personal contributions with access guaranteed.
Liberal systems
These are typical of the US, UK, Australia and New Zealand. Income support, social and health services are less comprehensive and only partially funded. This has encouraged the emergence of two-tiered systems with significantly greater levels of income inequality and access.
NB There are other ways of classifying welfare states, but the one used here is the most simple and useful.

While welfare states proliferated in the 1940s and 1950s, there was a counter argument that state intervention would lead to totalitarianism. In the 1960s Milton Friedman and others rejected the view that government intervention could lead to improved economic performance. Friedman articulated again the primacy of markets and competition, and a lesser role for the state as the way to improve productivity and efficiency.[3] By the 1970s this thinking had crystallised into the political/economic model known as neoliberalism, with the following key elements:

Economic restructuring, markets and privatisation—increased competition; removal of the state from commercial activity, greater openness to international trade and investment, freedom of movement of capital, labour and goods ('globalisation').

Limiting public expenditure on social services, including healthcare and education, and infrastructure, with debt reduction the major goal (later called 'austerity' policies).

Deregulation and promotion of individual responsibility—limiting government regulation that might inhibit economic activity, despite risks to personal health and safety or the environment; giving priority to individual responsibility and 'choice' over concepts of 'public good' or 'community'.

Led by conservative politicians, a 'great reversal'[3] occurred, with Keynesianism replaced by neoliberalism. Led by Ronald Reagan (US president 1981–89) and Margaret Thatcher (UK prime minister 1979–1990) the 'uptake' of neoliberalism was widespread internationally, and reinforced by financial institutions such as the International Monetary Fund (IMF) and the World Bank. These organisations, throughout the 1980s and 1990s forced unwilling but indebted countries to restructure their economies along neoliberal lines.

Neoliberalism in New Zealand

As a liberal welfare state New Zealand was well-positioned to move along the continuum to neoliberalism. Surprisingly, it was a Labour government, elected in 1984, that thrust neoliberal policies onto an unsuspecting public. Through two terms of government (1984–90) the neoliberal approach, called 'Rogernomics' after Finance Minister Roger Douglas, was introduced quickly and without effective opposition.[5] Minister Douglas himself stated: "Once the program begins to be implemented, don't stop until you have completed it. The fire of opponents is much less accurate if they have to shoot at a moving target".[6]

Neoliberal reform focused on monetary policy and on restructuring the commercial and service activities of the state. The exchange rate was floated, financial markets deregulated and most producer subsidies and import tariffs phased out. Many state commercial activities were corporatised and privatised. The Government reformed the public sector based on a preference for what were perceived to be private models of management, with a preference for private

provision, competition, labour flexibility and contractual arrangements. In deference to its traditional supporters it did not attempt major labour or welfare reform. It did, however, attempt to create a market for healthcare but this was resisted by Labour supporters and health professionals.[5]

The new National government (1990–96) pressed on with neoliberal policies. Severe cuts to welfare occurred in 1991 along with legislation to deregulate and create a more 'efficient' labour market.[7] The aim of health reform policy (1991) was to increase efficiency through privatisation and a competitive market, and opportunities for innovation.[5] The development of not-for-profit (NFP) organisations providing health services to Māori, Pasifika, youth and mentally ill people were important innovations to benefit the community, but otherwise there was a retreat from the excesses of the 1991 policy, first under a coalition government (1997–99) and a Labour government 2000–2009. Nevertheless, as the theory and practice of the New Public Management became consolidated in the 1990s, its business culture became embedded in the health system where it still pervades language and the planning and delivery of services.[8]

The general impacts of neoliberalism

Despite growth in world economic activity from the 1990s onwards, research appraisals of the impact of neoliberalism are mixed. Some say that there is 'much to cheer about',[9] claiming that globalisation removed many people worldwide from poverty and that privatisation of state enterprises increased efficiency and lowered the fiscal burden on governments. Nevertheless, research suggests that there have been poor outcomes for the most vulnerable economies, with most middle- and low-income countries experiencing slower economic growth and reduced progress on social indicators from 1980–2005, compared with previous decades.[10]

There are two areas of exceptionally poor outcomes: income inequalities arising from uncontrolled capital movements (globalisation), and service failure from austerity measures, leading to further inequality.[9] Research into 140 countries from 1970–2014 indicates that increased capital movements and income inequality are positively correlated across all countries.[11] In addition, international lending programmes that required reduced public spending were also associated with increased income inequality. From the 1980s, such 'structural adjustments' were a condition of international loans, forcing countries to reduce public services, with poor social and economic consequences. Research from 1985–2014 indicates that structural adjustment continues to inhibit the ability of governments to plan and provide public services.[12]

In New Zealand, the impacts of the reforms were catastrophic, with over 111,000 jobs lost between 1986 and 1996.[14] The cuts to welfare benefits created extra financial pressures on families with children. Child poverty rose dramatically after the 1991 budget and persisted, with 28% of children in poverty, including 20% in severe poverty in 2015.[14] In 2015 New Zealand, previously considered a low-inequality country, experienced one of the more significant rises in economic inequality in the OECD since the 1980s, similar to that of the US. [15]

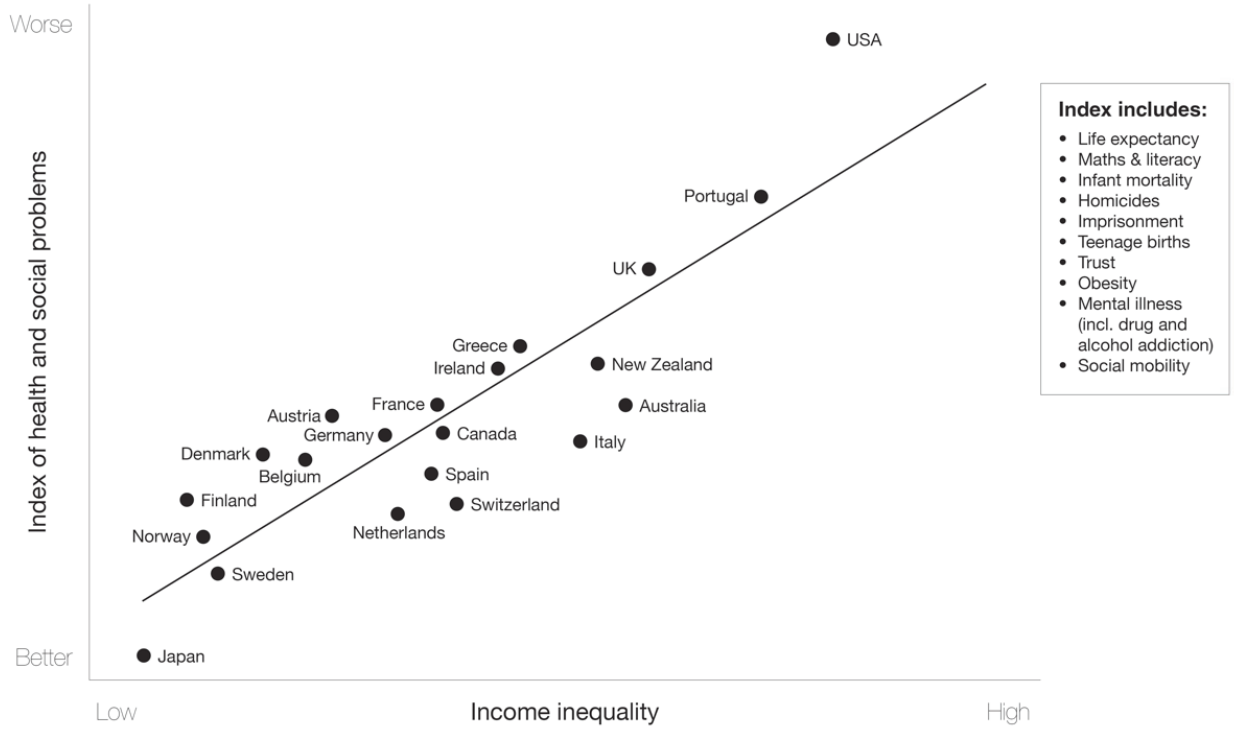
The impact of neoliberalism on health

Inequalities and health

The link between social and economic inequality and ill-health is well established. On virtually all health indicators across countries of all types, health outcomes from the most obvious (such as mortality rates and life expectancy) to the more subtle (mental health problems and chronic disease) are related to levels of inequality.[16] The graph (Figure 1; published with permission) from Wilkinson and Pickett powerfully demonstrates the relationship between increasing income inequality and a rise in the index of health and social problems.

Research worldwide has shown how poor health outcomes are related to deterioration in the social and economic determinants of health, such as income, housing, food security, employment, stress and educational opportunities.[17] Poor social conditions are not accidental, but result from neoliberal policies that affect not only mortality but also morbidities such as obesity, mental health and health risk behaviours. In New

Figure 1: Health and social problems are worse in more unequal countries.



Source: Wilkinson & Pickett, The Spirit Level (2009)

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Zealand these relationships have been demonstrated over decades,[18] with health risks from neoliberalism borne disproportionately by Māori and Pacific people[19] and exacerbated by the experience of cultural loss, colonisation and racism.[20]

Poor health outcomes are 'downstream' effects, but tackling 'upstream' causes requires policies to improve levels of social and economic wellbeing that will help people to live healthy lives. This involves recognising the continuing presence of income and social inequality: in New Zealand in the 1980s someone in the richest 10% earned five times as much as someone in the poorest 10%; now they earn eight times as much.[21]

Austerity policies and health sector reform

Besides the poor economic performance associated with austerity,[10] there is also a negative relationship between austerity and health. First, as already discussed, is the 'social risk effect', or 'risk-shifting'[22] where those already disadvantaged bear the consequences of deterioration in the determinants of health. The second is through the direct impact on health services. For example, after the Global Financial Crisis of 2008, health outcomes for countries where health budgets were reduced compared unfavourably with countries that protected spending on public services.[23] In New Zealand, health service impact is caused by both persistent underinvestment in services, competitive approaches and the marginalisation of health professionals in decision-making.

Underinvestment in health services

Government claims of overfunding in health services in the late 1980s were rejected by professional economists,[24] but the narrative of 'overfunding' was reinforced by self-interested private organisations and neoliberal governments. In fact, there is no indication of unsustainable funding between 2000–2015.[25] Measures of health expenditure for 2009–2018, adjusted for inflation and population change, based on Treasury models, indicated a cumulative decline.[26] The result was an effective reduction in funding for health services.

Persistent district health board deficits are most likely due to chronic underfunding of legitimate and growing needs by an estimated $2.5 billion over the last 10 years.[25,26] A further consequence of underinvestment over several decades is a demoralised workforce that found health workers in understaffed teams and poorly remunerated. Hospital doctors[27] and nurses[28] report stress, burnout and "intense, unrelenting work-loads".

Privatisation, corporatisation and inequalities in access

The 1991 health reforms were implemented specifically to create efficiencies by attempting to 'mimic' a private market in the public sector. This was unsuccessful because of community and professional scepticism. The introduction of 'user pays' for hospital stays in the early 1990s drew public ridicule and was abandoned. There was encouragement of private insurance models, but these received critical opposition.[29] The corporate model failed to improve hospital financial performance and as early 1996 the government's own monitoring agency reported that "the pace of performance improvement seems … to have weakened since the reforms".[30]

By attempting to drive unrealistic financial goals, aggressive management subverted health professional/management relationships, creating mistrust that compromised service quality and culture. This was seen notably in Canterbury where a group of concerned clinicians released a report 'Patients are Dying'. An investigation by the Health and Disability Commissioner (1996) explicitly blamed some patient deaths on systems changes and inadequacies, and led to some tempering of the excesses of the reforms.[31]

While the public health sector was not privatised and remained in public ownership, private sector business practices and culture were embedded in public organisations. The experience of the next two decades reflected continuing underinvestment, the transaction costs of contracting in the 'fake' market and the determination of funders to push financial risk onto local services or the community. For example, NFP community organisations were made to compete against each other in complicated tendering processes. The use of private facilities for contracting out services was encouraged and still persists, despite evidence that this may weaken elements of both public and private sectors.[32]

Despite some retreat from neoliberalism after the year 2000, there has been persistent marginalisation of health professionals through the dominance of rules and guidelines over clinical judgment. Since the late 1990s, for example, the National Waiting Times Project has given priority to rationing criteria over clinical decision-making in allocating elective surgery. These criteria and financial 'thresh-holds' have led, two decades on, to explicit concerns about unmet need.[33,34] Those with means can access private surgery while those without are often unable to access the care they need through public hospitals. In 2018, private hospitals reported performing 50% of all elective procedures (http://www.nzpsha.org.nz). Problems of access, however, go beyond surgical services. In primary care, cost barriers to access originate in the resistance of general practice to participating fully in Welfare State legislation in New Zealand in 1938. The long-term consequences of this are seen in multi-country studies of primary care from 1998–2016 where the proportion of New Zealanders unable to access a GP each year because of cost was on average 21%, second only to that of the US (34%).[35]

Regulation for health protection

Using regulation to improve population health is the cornerstone of public health action. Neoliberal governments often downplay their regulatory responsibilities, citing the paramountcy of 'personal responsibility' and 'personal choice'. In this they find willing partners among commercial interests.

The deregulation of the labour market has impacts for health. Research in both rich and poor countries shows that workers in 'precarious,' 'casual' or 'zero hours' work have poorer health outcomes.[36] The growth of the 'Precariat' is a worldwide phenomenon with up to one-sixth of working age people in New Zealand in this group.[37] The lives of the 'Precariat' are dominated by poor pay and lack of security, with stress a likely health outcome of 'low personal control' over work environments.[36] Similarly, neoliberal deregulation of work

and safety practices create health risks. In New Zealand, a review of the Pike River Mine tragedy in which 29 coal miners died in 2010 indicated serious regulatory failure attributed to neoliberal influences.[38]

In terms of housing, the desire to see business work in an unfettered way led to self-regulation of the construction industry through the Building Act 1991, resulting in poor standards of construction and 40,000 'leaky buildings'. This created health and financial consequences and required re-regulation to raise construction standards. In contrast, research indicates how regulation and interventions to ensure housing insulation can lead to important health benefits by improving energy performance.[39]

In the social sphere, the neoliberal position is that individuals usually make the best 'choices' for themselves, with regulatory approaches characterised as 'nanny state'. The entire apparatus of 'health promotion' appears to have lurched in this individual direction, despite evidence that education alone may not be particularly effective in areas such as alcohol consumption, injury prevention, tobacco control and dietary change.[40] This is another instance of trying to change 'downstream' behaviour instead of working on 'upstream' determinants of health inequalities or taking a responsible approach to providing a regulatory environment that can support behaviour change.

Particularly damaging is the way in which 'personal responsibility' and 'choice' have led to the stigmatisation of the most vulnerable, blaming individuals for their poverty, precarious employment and poor health. Nevertheless, there is optimism in the evidence that regulation and combined regulatory/personal approaches for health gain can be effective.[41]

Reappraisal and moving forward: health funding is an investment, not a cost

As a 'liberal' welfare state (Figure 1), New Zealand was vulnerable to and fell head-first into the neoliberal 'trap', and we have found it difficult to climb out. Neoliberalism persists when it seems so obviously bad for us, perpetuated by the 'haves' who are clearly doing quite well. There is an 'infrastructure of persuasion'[42] that includes relentless messages that embed neoliberalism in our psyche; language exerts a powerful influence as the persistence of the 'nanny state' critique shows.

Clearly there was some retreat from neoliberalism under a Labour government between 2000–2008, but push-back from National occurred from 2009–2016. The present prime minister, Jacinda Ardern has declared that neoliberalism has failed,[43] with the Government moving to strengthen the social determinants of health and raise income levels. Health services have received some modest additional funding to improve primary care access, resource mental health and assist district health boards with capital charges.

To do better, we must reject old-fashioned economic thinking that spending on health or other services is a burdensome cost. In fact, it represents a great investment; producing significant social benefits and promoting economic growth.[41] Risks from government spending in developed countries with little debt (such as New Zealand) are low, and even the IMF now acknowledges the past economic damage from austerity and that investment in public services/works provides both social and economic returns. Research into health spending in 25 European Union countries 1995–2010 indicates that the 'multiplier' effect (ie, the financial benefits) from government spending was 1.61 overall, but health spending achieved a multiplier of 4.9.[44] Therefore, for every dollar invested in health, there is a return of nearly $5 to the economy overall.

A focus on 'upstream' solutions through non-precarious employment and modest income re-distribution to create a 'proportionate universalism' (a balance between targeted and population approaches)[45] can address existing and prevent future inequalities. It will be important to rectify chronic health services underfunding by further increasing allocations, but we also need to address deficiencies within the health system.[46,47] The recent health and disability systems review suggests that some reorganisation is required to address problems of inequity, including poor Māori health outcomes, and lack of leadership, and hints at the need for rationalisation of structures.[46] There is increasing acceptance that there are too many DHBs and that these

add little value. Stronger central policy leadership and support for the integration of all aspects of primary, secondary, NFP community organisations and particularly the long-neglected population health services will be required.

In conclusion, the national (and international) impact of neoliberalism on health and healthcare remains enormous. In order to reverse it in New Zealand, a sea change is needed in philosophy, policy and practice with: (i) the immediate objective of equity of health outcomes for all citizens; (ii) bold re-investment in health and social security; (iii) the explicit rejection of the marginalisation of health professionals in decision-making, and (iv) a move to a more streamlined, ambitious and integrated health system.

Competing interests:
Nil.

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